COMMITTEE ON HEALTH, HOSPITALS AND HUMAN SERVICES

02/13/06-NO ACTION TAKEN

DECEMBER 1, 2005

An Act amending titles 3 and 22 Virgin Islands Code, to authorize and regulate third party administrators to administer health insurance policies to establish multiple employer trusts; to require insurance carriers to provide certain minimum core coverage for health insurance policies sold in the Virgin Islands; to establish the Virgin Islands Premium Assistance Program; to establish the Office of Health Care Policy and Finance; and for other purposes

Senators Roosevelt St. C. David, Lorraine L. Berry,
Craig Barshinger, Louis Patrick Hill and Ronald E. Russell

WHEREAS, the lack of adequate funding for the operations of, and improvements to, hospitals and other health care facilities in the Virgin Islands has had an adverse impact on the delivery of health care services in the Virgin Islands and has reduced the standard of care, especially for those without health insurance; and

WHEREAS, studies confirm that those who do not have health insurance available to them generally lack the financial access to health care services have a lower level of overall physical health as compared to others in the population who do have health insurance coverage; and

WHEREAS, one of the reasons for the lack of adequate funding has been the inability of hospitals and other facilities to collect fees from patients for the services provided; and

WHEREAS, the inability to collect fees is often because the patient is uninsured; and

WHEREAS, the cost of providing health insurance in the present market in the Virgin Islands is high, and the availability of coverage is inadequate; and

WHEREAS, one of the primary reasons for the high cost of health insurance in the Virgin Islands is that the risk pool is too small; and

WHEREAS, the cost to provide health insurance coverage can be significantly reduced, and the availability of insurance coverage increased, if the number of insured persons is increased; and

WHEREAS, encouraging employers and self-employed persons to obtain health insurance for their employees and themselves will help to accomplish simultaneously the three goals of increasing the funds available to hospitals and health care facilities in the Virgin Islands thus permitting a higher standard of care, making available health insurance to more residents of the Virgin Islands thus allowing them to obtain needed health services, and making health insurance coverage more affordable; and

WHEREAS, to achieve these goals, it is necessary to determine minimum core health care coverage that insurance companies shall make available; and

WHEREAS, to achieve these goals, it is also necessary to allow multiple employers to collaborate together to purchase health insurance for all of their employees; and

WHEREAS, such collaboration should take the form of one or more multiple employer trusts to purchase the insurance, a trustee to manage the trust, and third party administrators to

administer health care plans for employers and multiple employer trusts, a solution that has met with success in other jurisdictions; and

WHEREAS, employers who do not purchase health insurance for their employees cause the cost of health care services to rise for everyone because their uninsured employees nevertheless require health cares services, but may not be able to pay for them; and

WHEREAS, employers who do purchase health insurance for their employees, and self-employed persons who purchase health insurance for themselves, bear the cost of those who are uninsured because of the large numbers of uninsured persons usually lead to higher premiums resulting in unaffordable health care for many residents of the Virgin Islands; and

WHEREAS, a remedy to this inequity is to require employers and self-employed person to purchase health insurance and to provide for an enforcement mechanism designed to ensure that health insurance is actually purchased; and

WHEREAS, the Government should subsidize a portion of health insurance premiums of persons who desire to purchase health insurance but can not afford to pay the premiums; NOW, THEREFORE,

BE IT ENACTED by the Legislature of the Virgin Islands:

SECTION 1. Title 22 Virgin Islands Code is amended by adding a new chapter 67 to read as follows:

Chapter 67. Third Party Administrators

§1901. Definitions.

For the purpose of this chapter:

(a) "Administrator" means any person, firm, or partnership that collects or charges premiums from, or adjusts or settles claims on, residents of the territory in connection with life,

accident or health coverage provided by a self-insured plan or a multiple employer trust, as defined in this chapter, the term includes administrative-services-only contracts offered by insurance companies, but does not include the following persons:

(1) An employer, for its employees or for the employees of a subsidiary or affiliated corporation of the employer;

(2) A union, for its members;

(3) An insurer licensed to do business in this territory;

(4) A creditor, for its debtors, regarding insurance covering a debt between them;

(5) A credit card-issuing company that advances for or collects premiums or charges from its credit card holders as long as that company does not adjust or settle claims; or

(6) An individual who adjusts or settles claims in the normal course of his practice or employment as an attorney-at-law and who does not collect charges or premiums in connection with life or accident or health coverage.

(b) "Covered Individual" means any individual eligible for life or accident or health benefits under a plan.

(c) "Contributions" means any money charged a covered individual, plan sponsor or other entity to fund the self-insured portion of any plan in accordance with written provisions of the plan or contract of insurance. The term includes administrative fees charged to a covered individual. Administrative fee means any compensation paid by a covered individual for services performed by an administrator.

(d) "Premiums" means any money charged a covered individual, plan sponsor or

other entity to provide life or accident or health insurance under a plan. The term premium shall include amounts paid by or charged to a covered individual plan sponsor or other entity for stop loss or excess insurance.

(e) "Charges" means any compensation paid by a plan sponsor or insurer for services performed by an administrator.

(f) "Administrator Trust Fund", hereinafter referred to as "ATF", means a special fiduciary account established and maintained by an administrator pursuant to section 1911 in which contributions and premiums are deposited.

(g) "Claims Administration Services Account", or "CASA", means a special fiduciary account established and maintained by an administrator pursuant to section 1911 from which claims and claims adjustment expenses are disbursed.

(h) "Plan Sponsor" means any person other than an insurer, who establishes or maintains a plan covering residents of the territory, including but not limited to plans established or maintained by two or more employers or jointly by one or more employers and one or more employee organizations, the association, committee, joint board of trustees, or other similar group of representatives of the parties who establish or maintain the plan. The term does not include:

(1) The employer in the case of a plan established or maintained by a single employer; or

(2) The employee organization in the case of a plan established or maintained by an employee organization.

No plan sponsor covered in whole by provisions of the Employee Retirement Income Security Act of 1974, 29 U.S.C. §1001, *et seq.,* (ERISA), as amended, shall be

covered by any of the provisions of this chapter to the extent that the provisions are inconsistent with or in conflict with any provision of ERISA.

(i) "Financial Institution" means any federal, state or territorial chartered bank or savings and loan institution which is insured by the Federal Deposit Insurance Corporation (FDIC) or the Federal Savings and Loan Insurance Corporation **(**FSLI**C**).

(j) "Plan" means any plan, fund or program established or maintained by a plan sponsor or insurer to the extent that such plan, fund or program was established or is maintained to provide through insurance or alternatives to insurance any type of life, accident or health coverage.

§1902. License required.

(a) No person may act as or hold himself out to be an administrator ninety days after the effective date of this chapter, unless duly licensed in accordance with this chapter. An administrator doing business in the Virgin Islands on the effective date of this chapter shall apply for a license within thirty days after the effective date of this chapter.

(b) In addition to any other penalty set forth in this Chapter, any person violating subsection (a) is guilty of a misdemeanor.

§1903. Application.

The applicant for a license shall file with the Commissioner an application upon a form prescribed by the Commissioner, which must include or have attached the following:

(1) The names, addresses and official positions of the individuals responsible for conducting the affairs of the administrator, including but not limited to all members of the board of directors, board of trustees, executive committee, or other governing board

or committee, the principal officers of the corporation, or the partners of a partnership, or the members and managers of a limited liability company;

(2) The supporting documents and other information as the Commissioner may prescribe which may include, but shall not be limited to the following: biographical affidavits of the principals, officers, directors, partners, and managers; audited financial statements of the applicant or related entities; a statement of the source of initial funding; a proposed business plan and a statement of the qualifications and capabilities of the applicant to carry out the plan; and copies of articles of incorporation and by-laws, partnership agreements, operating agreements, shareholder agreements, and other organizational documents; and

(3) A non-refundable filing fee to be established by the Commissioner becomes the initial administrator's license fee should the Commissioner issue an administrator's license.

§1904. Bond requirements for administrators.

(a) Every applicant for an administrator's license shall file with the application and maintain while so licensed, a fidelity bond in favor of the Government of the Virgin Islands executed by a surety company and payable to any party injured under the terms of the bond. The bond must be continuous and in one of the following amounts:

(1) For an administrator that maintains an ATF but does not maintain a CASA, the greater of $50,000 or 5% of contributions and premiums projected to be received or collected in the ATF for the forthcoming plan year from Virgin Islands residents, but not to exceed $1,000,000;

(2) For an administrator that maintains a CASA but does not maintain an ATF, the greater of $50,000 or 5% of the claims and claim expenses projected to be held in the CASA for the forthcoming year to pay claims and claim expenses for Virgin Islands residents, but not to exceed $1,000,000;

(3) For an administrator that maintains both an ATF and a CASA, the greater amount in subparagraphs (1) or (2), but not to exceed $1,000,000.

(b) Notwithstanding paragraphs (1), (2), and (3) of this subsection, upon an administrative finding by the Commissioner that the amounts prescribed in one or more of the paragraphs provide inadequate protection to the public, the Commissioner may, by rule, prescribe higher amounts. The bond is required of an administrator who maintains or should maintain funds in a fiduciary capacity as set forth in section 1911 of this chapter, unless the administrator has contracted with the insurer as an administrator and if the plan is fully insured by the insurer on whose behalf the funds are being held.

(c) The bond remains valid until the surety is released from liability by the Commissioner or until the bond is cancelled by the surety. The surety may cancel the bond and be released from further liability upon 30 days' advance written notice to the Commissioner. The cancellation does not affect any liability incurred or accrued under the bond before the end of the 30-day period. Upon receipt of any notice of cancellation, the Commissioner shall immediately notify the licensee of the cancellation.

(d) The license required by section 1902 automatically terminates if the bond required is cancelled or otherwise not valid. Within 30 days after cancellation or invalidity of the bond, the administrator shall return the license to the Commissioner for cancellation.

§1905. License

(a) The Commissioner shall issue a license to each applicant who has complied with the requirements of this chapter.

(b) Each administrator's license remains effective as long as the holder of the license maintains a valid bond as required by section 1904 and pays the annual fee to be established from time to time by the Commissioner prior to the anniversary date of the license, unless the license is revoked or suspended pursuant to section 1907.

(c) Each license must contain the name, the business address, the identification number of the licensee, the issue date and any other information the Commissioner considers necessary.

§1906. Administrator requirements

(a) Each administrator must advise the Commissioner of any ownership interest or affiliation of any kind with any plan sponsor or insurer responsible directly or through reinsurance for providing benefits to any plan for which the administrator provides services.

(b) The administrator must provide services pursuant to a written agreement. The agreement must be between the administrator and the plan sponsor or insurer and must be retained as part of the official records of the administrator for the term of the agreement and for five years after the expiration of the agreement.

(c) The administrator must maintain in its principal office for the term of the agreement and for at least five years after the expiration of the agreement, books and records of all transactions involving a plan sponsor or insurer and covered individuals or beneficiaries. The books and records must be maintained in accordance with generally accepted standards of business recordkeeping. An administrator is not required to maintain copies of books and

records if the originals are returned to the plan sponsor or insurer prior to the end of the five-year period. The administrator shall maintain evidence of the return of the originals for the remainder of the five-year period.

(d) The administrator shall file with the Commissioner the names and addresses of the insurers and plan sponsors with whom the administrator has service agreements. If an insurer or plan sponsor does not assume or bear the risk, the administrator must disclose the name and address of the ultimate risk bearer. This filing requirement applies to the initial application for an administrator's license and for the renewal of licenses.

(e) An administrator may use only advertising for the plan that has been approved by the plan sponsor or insurer and which conforms to the requirement of chapter 49 of this title.

(f) Upon receipt of instructions from the plan sponsor or insurer, an administrator shall deliver promptly to covered individuals or beneficiaries all policies, certificate booklets, termination notices or other written communications, all of which shall conform to any rules and regulations promulgated by the Commissioner.

(g) An administrator may not receive compensation from a plan sponsor or insurer which is contingent upon the loss ratio of the plan. This subsection does not prevent the administrator from engaging in cost-containment activities with a plan sponsor or insurer.

(h) An administrator may not receive from any plan sponsor, insurer, covered individual or beneficiary under a plan any compensation or other payments, except as expressly set forth in the agreement between the administrator and the plan sponsor or insurer.

(i) From time to time, the Commissioner may examine the administrator’s affairs, transactions, accounts, records, documents, and assets. The provisions of chapter 5 of this title apply to the examinations as if the administrator were an insurer under this title.

§1907. License suspension, revocation or denial

(a) Any license issued under this chapter may be suspended or revoked, after notice to the licensee and an opportunity for hearing, and any application for a license may be denied, after notice and an opportunity for hearing, if the Commissioner finds that the licensee or applicant:

(1) has willfully violated any applicable provisions of this title; or

(2) has intentionally made a material misstatement on its application for a license; or

(3) has obtained or attempted to obtain a license through misrepresentation or fraud; or

(4) has misappropriated or converted to its own use, or improperly withheld, money required to be held in a fiduciary capacity; or

(5) has, in the transaction of business under its license, used fraudulent, coercive or dishonest practices, or has demonstrated incompetence, untrustworthiness or financial irresponsibility; or is not of good personal and business reputation; or

(6) has been, within the past three years of the issuance of the license, convicted of a felony, unless the individual demonstrates to the Commissioner sufficient rehabilitation to warrant the public trust; or

(7) has failed to appear without reasonable cause or excuse in response to a subpoena, examination warrant or any other order lawfully issued by the Commissioner; or

(8) is using such methods or practices in the conduct of its business so as to render the administrator's further transaction of business in this territory hazardous or injurious to covered individuals or the public; or

(9) is affiliated with and is under the same general management as another administrator that transacts business in this territory without a license issued under this chapter; or

(10) has had its license suspended or revoked or its application denied in any other state, district, territory or province on grounds similar to those stated in this section; or

(11) has failed to report under section 1908 a felony conviction.

(b) Denial of an application, suspension or revocation of a license, pursuant to this section must be by written order sent to the applicant or licensee by certified or registered mail at the address specified in the Commissioner's records. The order must state the grounds, charges or conduct on which denial, suspension or revocation is predicated upon. The applicant or licensee may make a written request a hearing within 30 days from the postmarked date of the Order, if mailed or form the date of receipt, if hand delivered. Upon receipt of the request for a hearing, the Commissioner shall issue an order setting (i) a specific time for the hearing which may not be less than 20 nor more than 30 days after receipt of the request for a hearing and (ii) a specific place and time for the hearing. If a written request for a hearing is not received by the Commissioner within the time specified, the order becomes final thirty days after the date of the order.

(c) Upon revocation of a license, the licensee or other person having possession or custody of the license shall return it to the Commissioner within 30 days of its revocation.

(d) Any administrator whose license is revoked, suspended, or whose application is denied under this section shall be ineligible to reapply for any license for two years from the date of revocation or suspension of the license or denial of the application. A suspension under this section may be for a period of up to two years.

§1908. Felony convictions.

Any administrator or any individual listed on the application as required by section 1903 who is convicted of a felony, must, within 30 days of the entry date of the judgment, (1) report the conviction to the Commissioner, and (2) provide the Commissioner with a copy of the judgment, the probation or commitment order and any other relevant documents.

§1909. Examination.

(a) The Commissioner or his designee may examine the records of any applicant for or holder of an administrator's license.

(b) Any administrator or applicant being examined must provide to the Commissioner or his designee convenient and free access during business hours to all books, records, documents and other papers relating to the administrator's or applicant's business affairs.

(c) The Commissioner or his designee may question under oath any employee, contractor or insurer about the business practices of the administrator.

(d) The examiners designated by the Commissioner may make reports to the Commissioner. Any report alleging substantive violations of this chapter must be in writing and must be verified by the examiners.

§**1910. Administrative fine.**

(a) If the Commissioner finds that one or more grounds exist for the revocation or suspension of a license issued under this chapter, the Commissioner may, in lieu of, or in addition to such suspension or revocation, impose a fine upon the administrator.

(b) The Commissioner may impose a fine upon an administrator not to exceed $5,000 for each violation for knowingly and willfully violating a lawful order of the Commissioner. In no event may the fine exceed an aggregate amount of $25,000 for any violations arising out of the same action.

§1911. Fiduciary accounts and duties.

(a) Administrators shall hold in a fiduciary capacity all contributions and premiums received or collected on behalf of a plan sponsor or insurer. The funds must not be used as general operating funds of the administrator. All contributions and premiums received or collected by the administrator from residents of the territory which the Administrator holds for more than fifteen days or deposits into an account that is not under the control of the plan sponsor or insurer, must be placed in a special fiduciary account, that must be designated as an "Administrator Trust Fund Account" ("ATF"). All licensees required to maintain an ATF under this section shall maintain the ATF with one or more financial institutions located within the Virgin Islands and subject to jurisdiction of courts located in the Virgin Islands. Funds belonging to two or more plans may be held in the same ATF, if the administrator's records clearly indicate which funds belong to which plan. Checks drawn on an ATF must indicate on their face that they are drawn on the ATF of the administrator.

(b) The administrator may make the following disbursements from an ATF:

(1) Contributions and premiums due insurers or other persons providing life or accident or health coverage for a plan;

(2) Return contributions and premiums to a plan or covered individual;

(3) Commissions or administrative fees due to the administrator when earned pursuant to written agreement; and

(4) Transfers into the CASA of the administrator.

(c) For each plan that requires an ATF, the balance at all times must be the amount deposited plus accrued interest, if any, less authorized disbursements. If AFT the balance is less than the amount deposited plus accrued interest, if any, less authorized disbursements, it is presumed that the administrator misappropriated fiduciary funds and has acted in a financially irresponsible manner.

(d) If the ATF is interest bearing or income producing, the full nature of the account must be disclosed to the plan sponsors or insurer. The administrator must secure written permission and authorization from the plan sponsors or insurers in order to be able to investment the funds or otherwise dispose of the interest or earnings. No investment may be made that assumes any risk other than the risk that the obligor shall not pay the principal when due. The use of specialized techniques or strategies that incur additional risks to generate higher returns or to extend maturities is not permitted. Such techniques include, but not limited to, the use of financial futures or options, buying on margins and pledging of ATF balances.

(e) Administrators may place ATF funds in interest-bearing or income-producing investments and retain the interest or income thereon, if the administrator obtains the prior

written authorization of the plan sponsors or insurers. In addition to savings and checking accounts, an administrator may invest in the following:

(1) Direct obligations of the United States of America or U.S. Government agency securities with maturities of not more than one year;

(2) Certificates of deposit, with a maturity of not more than one year, issued by financial institutions which are insured by the Federal Deposit Insurance Corporation (FDIC) or Federal Savings and Loan Insurance Corporation (FSLIC), so long as the deposit does not exceed the maximum level of insurance protection provided to certificates of deposits held by such institutions;

(3) Repurchase agreements with financial institutions or government securities dealers recognized as primary dealers by the Federal Reserve System provided:

(A) The value of the repurchase agreement is collateralized with assets which are allowable investments for ATF funds; and

(B) The collateral has a market value at the time the repurchase agreement is entered into at least equal to the value of the repurchase agreement; and

(C) The repurchase agreement does not exceed thirty days.

(4) Commercial paper, provided the commercial paper is rated at least P-1 by Moody's Investors Service, Inc. or at least A-1 by Standard & Poor's Corporation;

(5) Money Market Funds, provided the money market fund invest exclusively in assets which are allowable investment under paragraphs (1) through (4) for AFT funds;

(A) Each investment transaction must be made in the name of the administrator's ATF.

(B) The administrator must maintain evidence of any investments. (C) Each investment transaction must flow through the administrator's ATF.

(f) The administrator shall be the trustee for all moneys that received to pay claims and claim adjustment expenses. All licensees shall place all money for claims and claim adjustment expenses for residents of this territory, whether received from a plan sponsor or insurer or from an administrator’s ATF, in a special fiduciary account in a financial institution located in this territory. The account is designated a "Claims Administration Service Account" ("CASA"). Funds belonging to two or more plans may be held in the same CASA, if the administrator's records clearly indicate which funds belong to each plan. Checks drawn on the CASA must indicate on their face that they are drawn on the administrator’s CASA.

(g) No deposit may be made into a CASA and no disbursement may be made from a CASA except for claims and claims adjustment expenses. For each plan where a CASA is required, the balance in the CASA must at all times be the amount deposited less claims and claims adjustment expenses paid. If the CASA balance is less than that amount, it is presumed that the administrator has misappropriated the funds and has acted in a financially irresponsible manner.

(h) (1) Administrators shall maintain detailed books and records which reflect all transactions involving the receipt and disbursement of:

(A) Contributions and premiums received on behalf of a plan sponsor or insurer; and

(B) Claims and claim adjustment expenses received and paid on behalf of a plan sponsor or insurer.

(2) The detailed preparation, journalizing and posting of books and records must be maintained on a timely basis and all journal entries for receipts and disbursements must be supported by evidential matter which must be referenced in the journal entry so that it may be traced for verification. Administrators must prepare and maintain monthly financial institution account reconciliations of all ATF and CASA established by the administrator. The minimum detail required is as follows:

(A) The sources, amounts and dates of any moneys received and deposited by the administrator.

(B) The date and person to whom a disbursement is made. If the amount disbursed does not agree with the amount billed or authorized, the administrator shall prepare a written record as to the reason.

(C) A description of the disbursement in such detail to identify the source document substantiating the purpose of the disbursement.

(i) Failure accurately and timely maintain the books and records shall be considered untrustworthy, hazardous or injurious to participants in the plan or the public and financially irresponsible.

§1912. Unauthorized activities.

Nothing in this chapter may be construed to permit any person or entity to receive, collect charges, contributions or premiums for, or adjust or settle claims in connection with any type of life, accident or health benefit, unless that person or entity is authorized through the insurance

laws of a state or territory, or the Employee Retirement Income Security Act of 1974, 29 U.S.C. §1001, *et seq.,* as amended (ERISA), to provide benefits.

§1913. Annual Reports.

Every administrator shall file an annual report in duplicate originals, with the Commissioner on or before March 30 of each year. The report must be on forms prescribed by the Commissioner, and must contain information, and attachments as the Commissioner may determine, including, but not limited to a disaggregation of all health insurance premiums received and claim payments made by the administrator from all other premiums and payments. The Commissioner may require that the payment of the license fee, and any applicable filing fees, must accompany the annual report. Promptly upon receipt of the annual report, the Commissioner shall transmit one duplicate original of the annual report to the director of the Office of Health Care Policy and Finance created under title 3 Virgin Islands Code, section 27i.

§1914. Rules and regulations.

Pursuant to title 22 Virgin Islands Code, chapter 3, section 53, the Commissioner may issue rules and regulations for the proper administration and functioning of the provisions of this chapter."

SECTION 2. Title 22 Virgin Islands Code is amended by adding a new chapter 69 to read as follows:

*"*Chapter 69. Multiple Employer Trusts and Multiple Employer Welfare Arrangements

§1951. Registration required.

(a) "Multiple employer welfare arrangement" has the same meaning set forth in 29 U.S.C. 1002 (40).

(b) Every multiple employer trust and every other multiple employer welfare arrangement that intends to provide accident or health benefits to residents of the Virgin Islands shall register with the Commissioner prior to soliciting or enrolling members or prior to conducting any other business activity in the Virgin Islands.

(c) Each multiple employer trust and multiple employer welfare arrangement conducting business in the Virgin Islands shall register with the Commissioner no later than thirty days after the effective date of this chapter.

(d) After the initial registration, each multiple employer trust and other multiple employer welfare arrangement conducting business in the Virgin Islands shall register with the Commissioner no later than January 1 of each year for as long as it continues to do business in the Virgin Islands.

(e) Every initial registration shall be accompanied by a copy of any trust agreement, contract or other formation documents of the multiple employer trust and every initial and subsequent registration shall be accompanied by documents or information that the Commissioner may prescribe by regulation.

§1952. Trustee of Certain Multiple Employer Trusts.

Any multiple employer trust that intends to provide accident or health benefits to employees of the Government of the Virgin Islands shall have as its trustee an entity that is licensed by the Commissioner. The trustee is responsible for contracting, on behalf of the Government of the Virgin Islands and other employers, for health and accident insurance coverages for their employees, collecting and paying premiums, and other matters as may be

determined by the Office of Health Care Policy and Finance established pursuant to title 3, Virgin Islands Code, section 27*i*, or by the Governor. The Office of Health Care Policy and Finance office, or the Governor, shall enter into a contract with the trustee to provide the services provided for in this chapter, under such terms and conditions as they may deem reasonable and appropriate.

§**1953. Rules and regulations.**

Pursuant to title 22 Virgin Island Code, chapter 3, section 53 of this title, the Commissioner shall issue rules and regulations not in conflict with this section for the proper administration and functioning of the provisions of this chapter. In addition, the Commissioner may issue such rules and regulations as the Commissioner determines are necessary for the protection of those intended to receive benefits through a multiple employer trust and any other multiple employer welfare arrangement that is required to register under this chapter including, but not limited to, regulations requiring the licensure of the multiple employer trust or the multiple employer welfare arrangement, or of the trustee, the requiring of the posting of performance bonds, the imposition of a reasonable registration or licensing fee, and the requiring of the filing of annual reports including annual financial reports. Licenses may be denied by the Commissioner so long as there is a reasonable basis for such denial."

SECTION 3. Title 22 Virgin Islands Code is amended by adding a chapter 71 to read as follows:

"**Chapter 71. Health Insurance Coverage, Premiums, and Premium Assistance**

§1971. Definitions.

For the purposes of this chapter the following terms have the following meanings:

(1) "Core coverage" shall have the meaning set forth in section 1973 of this chapter;

(2) "Employer" has the same meaning as that set forth in title 24 Virgin Islands Code, section 302 (i); or a self-employed person, except as provided in paragraph (4); and includes any employing unit that is a limited liability company. The term excludes the Government of the Virgin Islands, the Government of the United States of America, and any foreign government, and any instrumentality of the Government of the Virgin Islands, the United States of America or any foreign Government.

(3) "Employee" means any person in respect of whose wages an employer is required to make contributions to the Unemployment Fund during the first quarter of any calendar year pursuant to title 24 Virgin Islands Code, section 308, or a self-employed person.

(4) A "self-employed person" means any person who has, or reasonably expects to have, net earnings from self-employment during the calendar year of $5,000 or more; except that any self-employed person who is a partner in a partnership, or a member of a limited liability company, which partnership or limited liability company is an employer that does or should provide health insurance to or on behalf of such partner or member, is considered to be an employee of such partnership or limited liability company and is not considered to be an employer.

(5) “Net earnings from self-employment” has the same meaning set forth in section 1402(a) of the United States Internal Revenue Code.

(6) “Net Premium” means the insurance premium for health insurance coverage less any government provided subsidy relating thereto; and

(7) "Federal poverty level" means, with respect to a household, the income poverty line as prescribed and revised at least annually pursuant to section 673(2) of the Federal Community Services Block Grant Act, 42 U.S.C. §9902(2), as it applies to the Virgin Islands pursuant to the Virgin Islands State Medicaid Plan, subject to any waivers which may be granted by the Centers for Medicaid and Medicare Services.

§1972. Core health insurance coverage required.

Except as otherwise provided in this chapter, any contract for health insurance issued in this territory on or after the effective date of this chapter, purporting to provide health coverage or benefits to residents in this territory, must provide benefits as are determined to be core coverage pursuant to section 1973 of this chapter; except that nothing in this chapter may be construed to prevent the issuance of health insurance policies or coverages that supplements or provides additional coverage to the core coverage. Any insurer providing core coverage in this territory may do so directly or through a reinsurance or similar arrangement with another insurer that is authorized to transact insurance business the territory.

§1973. Core coverage defined.

(a) As of the effective date of this chapter, the term "core coverage" as used in this chapter means health insurance coverage that provides at least the following benefits to the insured:

(1) Average Semi-Private Hospital Room and Board for up to 60 days;

(2) Hospital Special Fees;

(3) ICU stays for up to 30 days;

(4) In Hospital Physician Charges;

(5) Surgery based on Reasonable and Customary Charges;

(6) Anesthetist Services;

(7) In Hospital Diagnostic Lab and X-ray;

(8) In Hospital Prescription Drugs;

(9) Ancillary Hospital Services;

(10) Ground Ambulance Services;

(11) In Hospital Nervous & Mental;

(12) In Hospital Drug Abuse & Alcohol;

(13) Maternity including Pre-natal and Post-natal care;

(14) Routine Physicals;

(15) Vaccinations, inoculations and other childhood care and treatment on a outpatient basis;

(16) Allergy and Asthma testing and treatment;

(17) Emergency Accident Care at the Emergency Room within 24 hours of an incident;

(18) Outpatient surgery performed by a qualified physician including charges of the physicians, surgery, hospital facilities and other ancillary charges incurred in a qualified outpatient surgical procedure;

(19) Preventive Medical Testing and Treatment for breast cancer, colon cancer, prostrate cancer, kidney disease, heart disease, diabetes, and other chronic illnesses affecting residents in the Virgin Islands;

(20) Physician visits in office or at home;

(21) Prescription Drug Plan for on-island out of hospital prescription drug charges, and for off-island out of network PPO providers, with a mail order option for long term maintenance drugs and prescriptions for generic drugs only;

(23) Routine physical examinations through on island physicians only;

(24) Vision Examinations;

(25) Dental Care and Treatment for preventive, restorative and major restorative services;

(26) Diagnostic Laboratory and X-ray benefits out of Hospital; and

(27) Air Evacuation to in-network PPO providers in Puerto Rico or the United States mainland.

(b) Core coverage as defined in subsection (a) of this section is subject to calendar year maximums, lifetime maximums, out-of-pocket caps, visits per year, coverage levels,

deductibles, co-insurance amounts, co-payments and other rules as are provided in subsection (c) of this section, or as may be determined by the Governor, pursuant to subsection (d) of this section. The calendar-year maximums, lifetime maximums, out-of-pocket caps, visits per year, coverage levels, deductibles, co-insurance amounts, co-payments and other rules may differ depending on the types of coverages as set forth in subsection (a) of this section, the location where services are provided, either within or without the Virgin Islands, and whether the provider is affiliated with one or more healthcare networks or preferred provider organizations. In addition, levels of co-payments for the prescription drug benefits may differ depending on whether the prescriptions are obtained on or off-island, by mail order, or are for generic or brand name drugs. There shall be no distinction in coverage levels, deductibles, co-insurance amounts, or co-payments for emergency care and treatment based on whether such treatment is provided within or without the Virgin Islands. Pre-existing conditions must be covered pursuant to the minimum standards provided under federal law including the federal Health Insurance Portability and Accountability Act or other applicable statutes.

(c) The calendar-year maximums, lifetime maximums, out-of-pocket caps, visits per year, coverage levels, deductibles, co-insurance amounts, co-payments and other rules applicable shall be effective for the first calendar year coverage as set forth in Appendix A to the Act.

(d) After the first year, the Governor may, after consultation with the Commissioner, by proclamation made no more frequently than once per calendar year, determine that core coverage means a level or type of health insurance benefits different from those set forth in subsection (a) of this section and make determinations with respect to calendar year maximums,

lifetime maximums, out-of-pocket caps, visits per year, coverage levels, deductibles, co-insurance amounts, co-payments and other rules which differ from those provided pursuant to subsection (c) of this section or which differ from those made in prior proclamations; provided, that the effective date of any such proclamation shall be at least 120 days subsequent to the date of the proclamation; and provided further that the proclamation be hand delivered to the President of the Legislature of the Virgin Islands within three business days of the date of the proclamation if the Legislature is in session, or within fifteen days if the Legislature is not in session. After delivery of the proclamation to the President of the Legislature, the Legislature may, by law, determine that the proclamation shall not take effect, or the Legislature may, by law, enact a different definition of core coverage than what is included in the proclamation. If the Legislature fails to act within 30 days of the effective date of the proclamation, the definition of core coverage set forth in the proclamation becomes the definition of core coverage as of the effective date of the proclamation.

§1974. Requirement of employers to provide health insurance.

(a) Except with respect to an employee described in subsection (c), every employer must provide health insurance to its employees who have been employed at least sixty (60) days. Each employee must provide requested information, complete and submit application forms, and take action as may be required by the employer to provide insurance coverage to the employee. An employee's failure to do so shall be construed as willful and intentional disobedience to reasonable and lawful instructions of the employer pursuant to title 24 Virgin Islands Code, section 76(a), paragraph (4).

(b) Any employer that provides health insurance to its employees, regardless of the type or level of coverage, must pay at least 50% of the premium for core coverage for each employee. The employer may pay in excess of 50% of the premium and the employer may pay any portion or no portion of the premium required to insure other members of an employee's family. The balance of the premium for the employee or the premium for the employee's family shall be paid by the employee.

(c) An employee may decline health insurance offered by an employer only if the employee: (1) certifies in writing to the employer that the employee has alternate insurance of a level and type which provides benefits equal the core coverage listed in section 1973, and (2) provides the employer with written proof of the coverage.

§1975. Employer's records; enforcement.

(a) Every employer must keep adequate records to prove its compliance with the provisions of this chapter, including proof of insurance as may be prescribed pursuant to rules and regulations.

(b) The Commissioner of Licensing and Consumer Affairs may examine the books, records, papers or other information bearing upon matters covered by this chapter, and he may require the attendance of an employer having knowledge of the books, records, etc. as may be necessary for proper enforcement of this chapter.

(c) The Commissioner of Labor, the Director of the Bureau of Internal Revenue, and the Commissioner of Finance, must provide assistance to the Commissioner of Licensing and

Consumer Affairs as he may reasonably request to assist in the enforcement of the provisions of this chapter.

§1976. Rules and regulations.

The Governor shall issue rules and regulations for the interpretation and enforcement of this chapter. The rules and regulations must set forth fines or other penalties for the failure to provide core coverage. The amount of the fine per employee who was not provided core coverage must be no less than two times the cost of the average monthly premium payable for core coverage per employee, as may be determined by such reasonable method as the Governor may prescribe, times the number of months core coverage was not provided. Pending the adoption of rules and regulations, the fine described in the preceding sentence must be imposed where core coverage was not provided. The rules and regulations must also establish the types of documents which constitute proof of insurance and must provide details for the keeping and retention by employers of the records as may be necessary for the enforcement of this chapter.

1977. Premium Assistance Program.

(a) There is established the Virgin Islands Health Insurance Premium Assistance Program ("HIPAP").

(b) An employee is eligible for HIPAP, if the employee is (1) required to pay a premium pursuant to section 1974 of this chapter, and (2) is a member of a household the income of which is greater than 100% of the federal poverty level and no greater than 300% of the federal poverty level.

(c) If an employee is eligible for HIPAP under subsection (b), HIPAP shall pay such fraction of any premium for health insurance coverage payable in respect of the employee and members of the employee's family as the Commissioner of Human Services may determine, provided that the fraction may not in any case exceed one-third of the cost of the premium.

(d) HIPAP may make such payments of premium to the insurance carrier, the employer, or to a third party administrator on behalf of the employer.

(e) Any employer that provides core coverage or other health insurance coverage in addition to core coverage to employees must provide information to employees regarding HIPAP and must offer assistance to employees in applying for HIPAP. The information must be provided, and assistance offered, to a new employee upon employment and to all employees annually.

(f) The Department of Human Services shall administer the HIPAP. The Commissioner of Human Services shall issue regulation for the proper administration and functioning of the provisions of this section.

§1978. Consistency.

Any provision of territorial law, or any requirement of territorial law with respect to the issuance of health insurance, including but not limited to any government health insurance plan adopted pursuant title 3 Virgin Islands Code, subchapter VIII, chapter 25, shall be construed to be consistent with the provisions of this chapter and in case of any conflict between this chapter and any law or requirement, the provisions of this chapter shall apply. Nothing in this chapter may be construed to conflict with any provision of the Employee Retirement Income Security

Act of 1974, 29 U.S.C. §1001, *et seq.,* as amended (ERISA), and to the extent that any provision of this chapter conflicts with any provision of ERISA, the provisions of ERISA shall govern. If it is determined that provisions of this chapter conflict with ERISA, only those provisions which conflict shall be nullified and any other provision which does not so conflict remains effective.

§1979. Exception.

This chapter may not be construed to alter or prescribe the health care coverage provided under the federal Medicare or Medicaid program nor shall it be construed to require any employer or employee to pay any premium, or any portion thereof, in respect of any person who is eligible for benefits under the federal Medicare or Medicaid program."

SECTION 4. Title 3 Virgin Islands Code is amended by adding a section 27*i* to read as follows:

"§27*i*. Virgin Islands Office of Health Care Policy and Finance and Virgin Islands Health Policy Advisory Council

(a) There is established within the Office of the Governor an Office of Health Care Policy and Finance, ("OHCPF"). The OHCPF is headed by a Director appointed by the Governor who shall receive a salary as may be determined by law. The purpose of the OHCPF is to advise the Governor regarding the availability of health care services in the territory, the level of health services, the funding for health services, the amount of fees charged for health services, the availability of federal aid for health services, the availability of health insurance and the premiums charged in the territory, the compilation of data regarding health services utilization as

a result of coverages provided by multiple employer trusts, and other matters relating to the financing of health care delivery in the territory as the Governor may from time to time determine. Specifically, the Director shall advise the Governor regarding matters requiring the Governor's proclamations set forth in title 22 Virgin Islands Code, chapter 71. The OHCPF has the authority request data and reports it may require from health care service providers and facilities as well as from insurers that provide health insurance to the residents of the territory. The Director may issue regulation for the proper functioning of the provisions of this section.

(b) There is established the Virgin Islands Health Policy Advisory Council ("VIHPAC"). The purpose of the VIHPAC is to advise the Governor of the coordination of the activities of all government agencies with respect to matters concerning health insurance, health care benefits, health care financing, health care fees, health care delivery, and other related matters.

(c) The members of the VIHPAC consist of the Commissioner of Insurance; the Commissioner of Health; the Commissioner of Human Services; the Commissioner of Labor; the chair of the Health Insurance Board of Trustees; the Director of the OHCPF, who shall serve as its secretary; the chair of the Health Committee of the Legislature, or any other committee that may be charged with responsibility for legislation and oversight of health care matters; and two members of the private sector to be appointed by the Governor. One of the private sector members must reside in District of St. Croix and the other in the District of St. Thomas and St. John. Private sector members shall each serve a term that expires upon the expiration of the term of the Governor who appointed them. The Chair of OHCPF shall be elected among its members

for a term not to exceed two years. Public sector members' terms continues for so long as they hold their respective positions.

(d) The VIHPAC shall meet at least once quarterly at a time and place its chair may determine. Private sector members are entitled to payment of travel expenses for travel to a meeting of the VIHPAC in a district other than the district in which they reside.

SECTION 5. (a) Consistent with title 3 Virgin Islands Code, subchapter VIII, chapter 25, the Health Insurance Board of Trustee, as established in title 3 Virgin Islands Code, section 631, shall contract for core coverage, as defined in title 22 Virgin Islands Code, section 1973, with one or more insurers. Such coverage applies to all eligible officers and employees and their dependents, including retirees, consistent with and pursuant to law, of the Government of the Virgin Islands, the University of the Virgin Islands, and the Virgin Islands Port Authority. In the discretion of the Health Insurance Board of Trustees, the coverage may be contracted through a third party administrator.

(b) The contract is subject to the approval of the Governor and becomes effective as of January 1, 2006 unless the Governor, by proclamation, prescribes a delayed effective date, but in no event may the delayed effective date be later than July 1, 2006. The contract must be for a term that the Health Insurance Board of Trustees considers appropriate and may be renewed for subsequent periods. The contract is subject to the appropriation and availability of funds.

(c) Nothing in this section may prevent the Health Insurance Board of Trustees from contracting for health insurance coverage in addition to, or in excess of, core coverage for officers, employees, and their dependents.

(d) Core coverage with respect to retirees must be altered to the extent necessary to take into account such health coverage as may be available to the retirees under Medicare.

(e) There is appropriated in the fiscal year ending September 30, 2006, funds from the Treasury of the Virgin Islands as may be required to fund the contract.

SECTION 6. The board of directors, or other executive authority, of every autonomous or semi-autonomous agency or instrumentality of the Government of the Virgin Islands, shall contract for core coverage, as that term is defined in title 22 Virgin Islands Code, section 1973 with one or more insurers. Such coverage applies to all eligible officers and employees and their dependents, including retirees, consistent with and pursuant to law, and the policies of such agencies and instrumentalities. Such coverage may be contracted through a third party administrator. The contract becomes effective on January 1, 2006, unless the Governor, by proclamation, prescribes a delayed effective date, but in no event may the delayed effective date be later than July 1, 2006. The contract must be for a term as the boards of directors or other executive authorities consider appropriate and may be renewed for subsequent periods. Nothing in this section may be construed to prevent the boards or executive authorities from contracting for health insurance coverage in addition to, or in excess of, core coverage for the officers, employees, and their dependents. Core coverage with respect to retirees must be altered to the extent necessary to take into account the health coverage as may be available to the retirees under Medicare.

SECTION 7. The Governor shall contract for core coverage, as defined in Title 22 Virgin Islands Code, section 1973, with one or more insurers for health insurance coverage applicable to all persons for whom the government provides free health care services, including persons who are eligible for such coverage under Medicaid, programs administered by the Department of Human Services, or other locally or federally funded programs. Such coverage may be contracted through a third party administrator. The contract becomes effective on January 1, 2006 unless the Governor determines that there shall be a delayed effective date, but in no event may the delayed effective date be later than July 1, 2006. The contract must be for a term the Governor considers appropriate and may be renewed for subsequent periods. Nothing in this section may be construed to prevent the Governor from contracting for health insurance coverage in addition to, or in excess of, core coverage for the persons referenced in this section. There is appropriated such funds from the Treasury of the Virgin Islands as may be required to fund the contract, and the Governor may obligate either federal or local funds for the purposes of the funding thereof.

SECTION 8. There is appropriated such funds from the Treasury of the Virgin Islands as may be required to fund: (1) the Premium Assistance Program established in section 3 of this Act during the fiscal year ending September 30, 2006; and (2) to engage a trustee pursuant to the provisions of title 22 Virgin Islands Code, chapter 69, section 1952, as provided in section 2 of this Act.

SECTION 9. Any employer required to provide core coverage, as defined in title 22 Virgin Islands Code, chapter 71, who, on January 1, 2006, has in effect an insurance policy which provides health insurance to its employees, may delay providing core until the earlier of the day after the date such insurance policy expires, either by its terms, or by cancellation by either the employer or the insurer, or January 1, 2007.

SECTION 10. (a) Section 3 takes effect on January 1, 2006, subject to section 9 of the Act.

(b) Section 4 takes effect on January 1, 2007.

EXPLANATION AND BILL SUMMARY

The proposed legislation is designed to create funding sources for Virgin Islands hospitals and other medical facilities primarily through encouraging and facilitating greatly expanded health insurance coverage opportunities to residents of the Virgin Islands.

Virgin Islands hospitals and other medical facilities have suffered chronic funding problems. In some cases these problems have had a negative impact on the level of health care that these facilities can provide to Virgin Islands residents. The funding problem relates in large part to the inability of a large numbers of users of Virgin Islands health care services to pay for the services they receive. While in many cases federal and local programs like Medicare and Medicaid provide the funding, these programs only apply to the elderly, other specially defined populations, and to the residents of the territory with the lowest incomes. Those whose employers provide health insurance to them, like government workers and employees of some of the larger private sector companies, for example, have their health care costs largely paid for them through their insurance policies.

However, there is a very substantial number of people who fall within none of these categories and who can not afford to pay for their health costs. This includes employees of smaller companies which do not offer insurance, employees of companies

that offer insurance but who can not afford the co-payments required to obtain coverage, the unemployed, and the self-employed, among others.

Compounding the above problem is the fact that, for insurance purposes, the Virgin Islands is a relatively small market. The availability and affordability of insurance depends, in large part, on the spreading of risk over a large number of insured persons. Because of its small population, and the relatively large number of persons covered by government programs like Medicare and Medicaid, the pool of available persons to be covered by private insurance is not large. Nevertheless, if a large enough percentage of potential insureds had insurance coverage, then the risk would be spread sufficiently for the health insurance market in the Virgin Islands to function as it does in other markets thus allowing affordable insurance to be more widely available.

The proposed legislation attempts to solve these problems by putting the legal tools in place to make it possible and, in fact, likely, that health insurance will be obtained by large enough numbers of Virgin Islands residents so that the great majority of hospital charges and other medical costs will be covered. This in turn will provide sufficient revenues to the hospitals and other health facilities that the quality of care should improve. Likewise, the more persons who obtain health cares services, because they can afford them, the healthier will be the population of the Virgin Islands.

The bill provides three main tools to achieve these objectives. First, section 1 of the bill provides for the establishment and regulation by the Commissioner of Insurance of third party administrators (TPAs). TPAs are private sector companies which are authorized to provide health insurance-related administrative services to employers and other persons who provide health insurance. They may be involved in many aspects of the insurance process, including collecting and paying over premiums to insurance companies, and processing and disbursing claims to insured persons. However, they are not insurance companies and they are not insurance agents. One of the main reasons for establishing TPAs is to create economic efficiencies so that multiple employers can group together and provide health insurance to all of their employees using a TPA for central administration of the policies. A TPA may provide services for a single employer, or many single employers, as well. The bill provides for TPAs to be licensed and bonded.

The second tool is the multiple employer trust (MET) which is established in section 2 of the bill. The MET is the legal vehicle through which health insurance for more than one employer is actually purchased. A MET is recognized under federal health insurance legislation (ERISA) as a health insurance plan. Two or more employers may form a MET and arrange for it to be administered by a TPA. Any MET operating in the territory will be required under the bill to register with the Commissioner of Insurance. Certain requirements are imposed with respect to the trustee of any MET

which is involved in obtaining insurance for employees of the Government of the Virgin Islands.

The third tool is in section 3 of the bill and it is a legal requirement regarding the types and levels of health insurance coverage that applies to all insurers that provide, or intend to provide, health insurance to residents of the Virgin Islands. Under present law, there is no regulation as to what types or levels of health insurance coverages an insurer may provide to residents. This can result in inconsistent and sub-standard coverage that may appear to be a bargain but which in fact provides inadequate benefits at too high a premium. Section 3 therefore provides a set of health insurance coverages which are considered to be core coverages and it requires that all health insurers selling insurance to Virgin Islands residents provide at least this amount of coverage. The core coverage requirement will enable the insurance industry to create insurance products which are tailored to the Virgin Islands market, thus making health insurance more of a Acommodity and less of a specialty item. By doing so, health insurance coverage should be easier to market and less expensive to provide, thus enabling more residents to obtain it. However, there is no restriction on carriers who wish to provide health insurance that is more comprehensive than core coverage or which has a higher level of benefits – carriers may do so provided as long as the coverage includes core coverage either directly or through a subcontract with another carrier.

The bill requires that all employers provide core coverage to their employees. The bill also specifies that health coverage that is greater than the core coverage may be provided as well. While the legislation provides an initial definition of core coverage, it also creates a process whereby the Governor may change the core coverage definition by proclamation from time to time after consultation with the Commissioner of Insurance (the Lieutenant Governor). It is expected that the Governor will use this authority based on consultations with the insurance industry. Before a revised definition of core coverage may take effect, the Governor must notify the Legislature and the Legislature would then have the opportunity to accept the revised definition or to enact a different definition in consultation with the Governor.

In addition to the core coverage requirement, section 3 of the bill provides that employers shall contribute at least 50% of the cost of health insurance premiums for core coverage for their employees. The employer may voluntarily contribute any or no amount to coverages for the families of employees or to any coverages in excess of the core coverage for employees. Any portion of health insurance premiums not paid for by employers shall be paid by employees. For low income employees (defined as those whose incomes are between one and two times the federal poverty level), section 3 also establishes a Health Insurance Premium Assistance Program (HIPAP) under which the government shall pay up to one-third of the health insurance premium. The balance of the premium for HIPAP eligible employees is paid by the employer and the employee in

the same proportions as are applicable for non-HIPAP eligible employees. It should be noted that persons who are at or below the locally-defined federal poverty level are potentially eligible for Medicaid and therefore need not participate in HIPAP. It is estimated that the cost of HIPAP subsidies plus the cost of subsidizing the operating costs of Virgin Islands hospitals and other health care facilities after the bill becomes effective shall be less than the amounts now required to be appropriated to subsidize the operations of Virgin Islands hospitals and other health care facilities only.

Other sections of the bill are designed to supplement and support the goals of the first four sections.

Section 4 of the bill establishes Office of Health Care Policy and Finance within the Office of the Governor. The purpose of the Office of Health Care Policy and Finance shall be to advise the Governor regarding the availability of health care services in the territory, the level of such services, the funding of such services, the levels of fees charged for such services, the availability of federal aid in respect of such services, the availability of health insurance and the premiums charged therefor in the territory, the compilation of data regarding health services utilization as a result of coverages provided by multiple employer trusts, or any other insurer, and other matters relating to the financing of health care delivery in the Virgin Islands.

Section 4 also establishes the Virgin Islands Health Policy Advisory Council (VIHPAC). The purpose of this council is to advise the Governor as to the coordination of the activities of all government agencies in respect of matters concerning health insurance, health care benefits, health care financing, health care fees, health care delivery, and other related matters. The VIHPAC shall consist of the Commissioners of Insurance, Health, Human Services, and Labor, the chair of the Health Insurance Board of Trustees, the Director of the OHCPF, the chair of the Health Committee of the Legislature, and two members of the private sector, one from each district. The VIHPAC shall meet at least once every quarter.

Sections 5 and 6 of the bill require that the health insurance policies purchased by the government and each of its autonomous or semi-autonomous agencies or instrumentalities, including but not limited to the Virgin Islands Port Authority, the University of the Virgin Islands, the Virgin Islands Water and Power Authority and the Virgin Islands Housing Authority, for the benefit of their respective employees, shall conform to the provisions of the bill relating to core coverage and authorizes that such coverage to be obtained through a third party administrator. Policies that meet this requirement are required to be in place by January 1, 2006 or, if the Governor so proclaims, at a later date but in no event later than July 1, 2006. Section 5 also contains a funding authorization for the purchase of the required government policies.

Section 7 of the bill likewise provides that the coverage provided by the Virgin Islands Medicaid program shall conform to the provisions of the bill relating to core coverage and authorizes that such coverage to be obtained through a third party administrator.

Section 8 of the bill authorizes appropriations for the funding of the Premium Assistance Program established in section 3 of the bill and for engaging a trustee for any multiple employer welfare trust that obtains insurance for Government employees as authorized in section 2 of the bill.

Section 9 provides that section 3 (mandating employers to provide core coverage and establishing the Premium Assistance Program) shall generally take effect on January 1, 2006 and section 4 (establishing the Office of Health Care Policy and Finance) shall take effect on January 1, 2007. The requirement of section 3 to provide core coverage, however, will have a delayed effective date with respect to employers who already have health insurance policies in place on January 1, 2006; such employers are required to have core coverage in place upon the earlier of the expiration of their current policy or January 1, 2007.

Section 10 provides that section 3 becomes effective on January 1, 2006, subject to section 9 and that section 10 becomes effective on January 1, 2007.

BR05-0503B/December 8, 2005/SR